

## END USER WORKBOOK—OB FLOWSHEETS

Kentucky Department for Public Health—March 2017



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# OB FLOWSHEETS WORKFLOWS

The following sections describe the end user OB Flowsheets workflows.

For more information about these workflows, and V10e, refer to the *eCW 101 OB Flowsheets Workbook* and the documentation available on the [my.eclinicalworks.com](http://my.eclinicalworks.com) Customer Portal.

**Note:** For information about patient safety, refer to the Patient Safety Advisory Letter, available on the [my.eclinicalworks.com](http://my.eclinicalworks.com) Customer Portal.

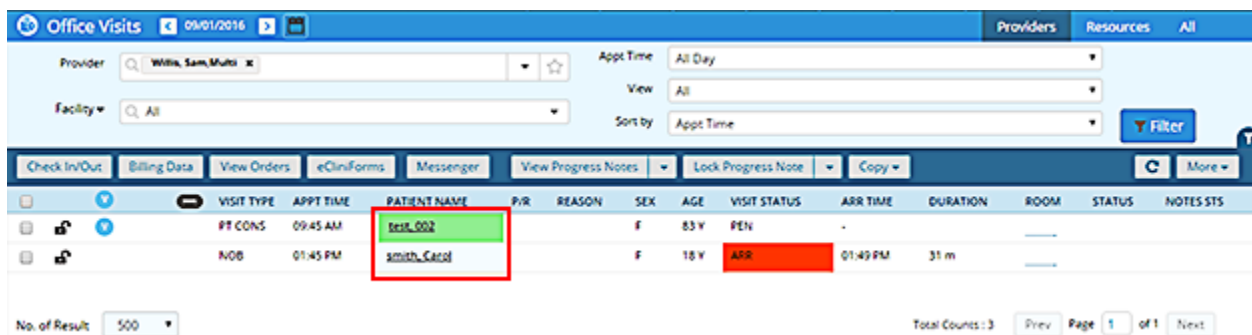
## Documenting the OB Flowsheets

The following sections describe the workflows for documenting in an OB Flowsheet.

### Accessing the OB Flowsheet

**Path:** *Main Menu > Practice icon > Office Visits*

Access the OB Flowsheet by double-clicking on the patient name link in the Office Visits window:



Use the Show/Hide toggle buttons next to the Patient Lookup icon to hide the Patient Dashboard and Interactive Clinical Wizard (ICW – formerly Right-Chart Panel).

Switch between the Progress Notes view and the OB view by clicking the *PN* or *OB* icon:



## Entering Pregnancy Information

Create and document a pregnancy for this patient from the Pregnancy List tab.

### Creating a New Pregnancy

**Path:** *OB Flowsheet > Preg List Tab*

Create a new pregnancy in the patient's OB Flowsheet.

**To create a new pregnancy:**

1. In the OB Flowsheet, click *Create Pregnancy*:

**OB Chart** [Icons] [Date: 04/12/2016]

**Patient Info:** Imm186.22 Test (19 Y), 03/05/1997

**Translator:** NO  
**Ethnicity:**  
**Race:**  
**Language:**  
**Interpretation Service Requested:** No  
**Req No:** 9135.25130  
**Primary Insurance:** RXHUB  
**Provider:** Sam Willis, MD  
**Referring Provider:**

**EMERGENCY CONTACT NO. FATHER INFORMATION**

**Risk Assessment:**  
 High Risk  
 At Risk  
 Genetics  
 Infection  
 Problem

**STICKY NOTES**

**PREG LIST** [Create Pregnancy]

Sr. No	Status	Father First Name	M. Initial	Father Last Name	Discharge Date	OB Provider	No. of Expected Children	Notes
No active pregnancy exists for this Patient. Please Create a new Pregnancy.								

[Right Sidebar: Preg List, Physical, History, Genetics, Form A, Flowsheets, Notes, EDD, Plans, Graphs]

2. In the Preg List section, select the new pregnancy and click the *Edit* icon:

**PREG LIST** [Close Pregnancy] [Edit Icon]

Sr. No	Status	Father First Name	M. Initial	Father Last Name	Discharge Date	OB Provider	No. of Expected Children	Notes
1	Open							

3. In the Preg Details window, enter the paternity details, the *Primary OB Provider*, and any additional details:

**Preg Details ( Test, Imm186.22 - 04/12/2016 - NOB )**

Navigation tabs: Preg Details, Physical, History, Genetics, Form A, EDD, Plans, Risks, Discharge, Post Partum

Discharge Date	MM/DD/YYYY
FOB First Name	
FOB Middle Initial	
FOB Last Name	
FOB DOB	MM/DD/YYYY
FOB Phone No.	
FOB Cell Phone No.	
FOB Occupation	
Primary OB Provider	
Race	
FOB Ethnicity	
Notes	

Buttons: OK, Close Pregnancy

4. Click *OK* to save the new pregnancy.

## Entering Total Pregnancy Information

**Path:** *OB Flowsheet > Edit pregnancy*

Enter the pregnancy conception and outcome details in the Form A window.

**To enter information about the patient's pregnancies:**

1. From the OB Flowsheet, select a pregnancy in the Preg List section and click the *Edit* icon.
2. In the Preg Details window, click the *Form A* tab.
3. Enter the additional information about the patient's previous pregnancies:

**Form A ( Test, Imm186.22 - 04/12/2016 - NOB )**

Navigation tabs: Preg Details, Physical, History, Genetics, Form A, EDD, Plans, Risks, Discharge, Post Partum

Previous Conception and Outcome		Menstrual History	
Name	Value	Name	Value
Total Preg.		LMP	mm/dd/yyyy
Full Term		Menses Monthly	
Premature		Frequency:Q	
AB, Induced		Menarche(Age onset)	
AB, Spontaneous		Prior Menses	
Ectopics		On BCP At Concept	
Multiple Births		HCG+Date	
Living			

Buttons: Lock, Copy Defaults, Merge Defaults, OK

4. Click *OK*.

## Entering Past Pregnancy Information

**Path:** *OB Flowsheet > Past Pregnancies*

Enter the pregnancy conception and outcome details in the Form A window.

**To enter information about the patient's past pregnancies:**

1. From the OB Flowsheet, in the Past Pregnancies section, click the plus (+) icon:



2. In the Past Pregnancy window, enter the specific information about the patient's previous pregnancies:

3. Click *OK* to save this information.

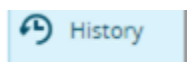
## Patient History

**Path:** *OB Flowsheet > History tab*

Enter the patient's surgical, family, social, medical, gynecological, obstetrical, and hospitalization history in the History tab of the OB Flowsheet.

**To enter the patient's historical information:**

1. From the OB Flowsheet, click the *History* icon in the right navigation bar:



The historical information from the Surgical History, Hospitalization History, Family History, Social History, Medical History, Allergies, and GYN History sections of the patient's past Progress Notes populate in the OB Flowsheet.

2. In the History tab, click the *Edit* icon next to a section to edit the patient's surgical, family, social, medical, gynecological, obstetrical, or hospitalization history:


**HISTORY**

**Surgical History** 

Date	Reason

**Hospitalization** 

Date	Reason

**Family History** 

Family Members	Status	Age(s)	Notes	Comments

**Social History** 

Social Info	Age(s)	Notes

**Medical History** 

History


**Allergies** 

Drug/Non Drug	Allergy

**Gyn History** 

Date	Symptom	Notes

3. In the OB Flowsheet History section, click the *Edit* icon:

**OB Flowsheet History** 

Name	Value	Remarks
Heart Disease		
Autoimmune Disorder		
Neurologic/Epilepsy		
Hepatitis/Liver Disease		
Thyroid/Dysfunction		
History of Blood Transfusion		
Alcohol		
D (Rh) sensitized		
Seasonal Allergies		
Breast		
Operations/Hospitalization		
History of abnormal PAP		
Infertility		
Diabetes		

Name	Value	Remarks
Hypertension		
Kidney disease/UTI		
Depression/PostPartum Depression		
Varicosis/Phlebitis		
Trauma/Violence		
Tobacco		
Illicit/Recreational Drugs		
Pulmonary (TB Asthma)		
Drug/Latex Allergies/Reactions		
GYN Surgery		
Anesthetic Complications		
Uterine anomaly/DES		
Relevant Family History		
Other		

4. In the History window, enter additional history information by selecting options from the drop-down lists and entering notes in the Remarks fields:

**History ( Test, Inm18622 - 04/12/2016 - NOB )**

Preg Details Physical **History** Genetics Form A EDD Plans Risks Discharge Post Partum

**OB Flowsheet History**

Name	Value	Remarks
Heart Disease	▼	
Autoimmune Disorder	▼	
Neurologic/Epilepsy	▼	
Hepatitis/Liver Disease	▼	
Thyroid/Dysfunction	▼	
History of Blood Transfusion	▼	
Alcohol	▼	
D (Rh) sensitized	▼	
Seasonal Allergies	▼	
Breast	▼	
Operations/Hospitalization	▼	
History of abnormal PAP	▼	
Infertility	▼	
Diabetes	▼	

Name	Value	Remarks
Hypertension	▼	
Kidney disease/UTI	▼	
Depression/PostPartum Depression	▼	
Varicosis/Phlebitis	▼	
Trauma/Violence	▼	
Tobacco	▼	
Illicit/Recreational Drugs	▼	
Pulmonary (TB Asthma)	▼	
Drug/Latex Allergies/Reactions	▼	
GYN Surgery	▼	
Anesthetic Complications	▼	
Uterine anomaly/DES	▼	
Relevant Family History	▼	
Other	▼	

Lock Copy Defaults Merge Defaults OK



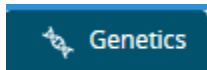
## Entering Genetics Information

**Path:** *OB Flowsheet > Genetics tab*

Enter the patient's genetic in the Genetics tab of the OB Flowsheet.

**To enter the patient's genetic information:**

1. From the OB Flowsheet, click the *Genetics* icon in the right navigation pane:



2. In the Genetics section, click the *Edit* icon:

Name	Value	Remarks
Patient's age > 35 years as of estimated date of delivery		
Neural Tube defect		
Down Syndrome		
Canavan disease		
Hemophilia or other blood disorders		
Cystic Fibrosis		
If yes, was person tested for fragile X		
Maternal metabolic disorder		
Recurrent pregnancy loss or a stillbirth		
If yes, Agent(s) and strength/dosage		

Name	Value	Remarks
Thalassemia (Italian, Greek, Mediterranean or Asian); MCV <80		
Congenital Heart Defect		
Tay-Sachs		
Sickle cell disease or trait		
Muscular dystrophy		
Mental Retardation/Autism		
Other inherited genetic or chromosomal disorder		
Patient or baby's father had a child with birth defects not listed		
Medications/Illicit/Recreational drugs/alcohol since last menstrual period		
Any other (see comments)		

3. In the Genetics window, enter the genetics information by selecting options from the drop-down lists and entering notes in the *Remarks* fields:

Name	Value	Remarks
Patient's age > 35 years as of estimated date of delivery		
Thalassemia (Italian, Greek, Mediterranean or Asian); MCV <80		
Neural Tube defect		
Congenital Heart Defect		
Down Syndrome		
Tay-Sachs		
Canavan disease		
Sickle cell disease or trait		
Hemophilia or other blood disorders		
Muscular dystrophy		
Cystic Fibrosis		
Patient or baby's father had a child with birth defects not listed		
Recurrent pregnancy loss or a stillbirth		
Medications/Illicit/Recreational drugs/alcohol since last menstrual		

4. Click *OK* to save the information.

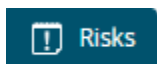
## Calculating the Patient's Risk Assessment

**Path:** *OB Flowsheet > Risks*

Calculate the patient's risk assessment in the Risks tab of the OB Flowsheet.

**To calculate the patient's risk assessment:**

1. From the OB Flowsheet, click the *Risks* icon in the right navigation pane:



2. In the Risks section, click the *Edit* icon.
3. In the Risks window, enter the date next the assessment for which the patient is identified to be *At Risk* or *High Risk*.

Risk Assessment:		
At Risk	Date	PL
Uterine/Cervical Malformation	mm/dd/yyyy	<input type="checkbox"/>
Suspect pelvis	mm/dd/yyyy	<input type="checkbox"/>
Rh Negative (nonsensitized)	mm/dd/yyyy	<input type="checkbox"/>
Anemia (HCT<30%, HGB<10%)	mm/dd/yyyy	<input type="checkbox"/>
Venereal disease	mm/dd/yyyy	<input type="checkbox"/>
Acute pyelonephritis	mm/dd/yyyy	<input type="checkbox"/>
Failure to gain weight	mm/dd/yyyy	<input type="checkbox"/>
Abnormal presentation	mm/dd/yyyy	<input type="checkbox"/>
Postterm pregnancy	mm/dd/yyyy	<input type="checkbox"/>
Alcohol use	mm/dd/yyyy	<input type="checkbox"/>

High Risk	Date	PL
Diabetes mellitus	mm/dd/yyyy	<input type="checkbox"/>
Hypertension	mm/dd/yyyy	<input type="checkbox"/>
Thrombophlebitis	mm/dd/yyyy	<input type="checkbox"/>
Herpes	mm/dd/yyyy	<input type="checkbox"/>
Rh sensitization	mm/dd/yyyy	<input type="checkbox"/>
Uterine bleeding	mm/dd/yyyy	<input type="checkbox"/>
Hydramnios	mm/dd/yyyy	<input type="checkbox"/>
Severe preeclampsia	mm/dd/yyyy	<input type="checkbox"/>
Fetal growth retardation	mm/dd/yyyy	<input type="checkbox"/>
Premature rupt. membranes	mm/dd/yyyy	<input type="checkbox"/>
Multiple pregnancy (preterm)	mm/dd/yyyy	<input type="checkbox"/>
Alcohol and drug abuse	mm/dd/yyyy	<input type="checkbox"/>

4. (*Optional*) Check the box next to an assessment to add it to the patient's Problem List.
5. Click *OK*.

The patient's risk is calculated. The list of risks display in the Summary section of the OB Flowsheet. High risks display in the *Problems* section, along with any risks that have been added to the patient's Problem List. High risks display in red.

## Adding Problems to the Patient Record

Add OB problems to the patient record, or assessments to the patient's Problem List.

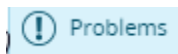
### Adding OB Problems

**Path:** *OB Flowsheet > Problems*

Enter the patient's surgical, family, social, medical, gynecological, obstetrical, and hospitalization history in the History tab of the OB Flowsheet.

**To add an OB problem to the patient's record:**

1. From the OB Flowsheet, click the *Problems* icon in the right navigation pane:



2. In the Problems section, click the first plus (+) icon:

 The screenshot shows the "PROBLEMS" section of the OB Flowsheet. It features a table with columns: Problem Date Identified, Problem, Action Taken, Entered By, Status, Initial, and Organize. Two rows are visible: "04/12/2016 Uterine/Cervical Malformation" and "04/04/2016 Diabetes mellitus". To the right of the table is a plus (+) icon in a red box. Below the table is a "Problem List" section with a plus (+) icon. The "Problem List" table has columns: Add to OB Problem, Code, Problem, WUStatus, and Clinical Status. One row is visible: "+ 171.4 Abdominal aortic aneurysm, without rupture confirmed".

3. In the OB Problem window, enter the patient's *Problem*, *Status*, *Initials*, and any *Action* taken for that problem:

 The screenshot shows the "OB Problem" window. It has a title bar with the text "OB Problem ( Test, Imm186.22 - 04/12/2016 - NOB )". The form contains fields for "Date" (04/12/2016), "Status" (a dropdown menu), and "Initials" (a text box). Below these is a large "Problem" text box. To the left of the "Problem" box is a blue button with a white exclamation mark icon. Below the "Problem" box is an "Action" text box. At the bottom right are "OK" and "Cancel" buttons.

4. Click *OK* to save the problem to the patient record.
5. In the Problems section, click the second plus (+) icon to add an assessment to the patient's Problem List.

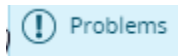
## Adding an Assessment to the Problem List

**Path:** *OB Flowsheet > Problems*

Add an assessment to the patient's Problem List in the Problems tab of the OB Flowsheet.

**To add an OB problem to the patient's record:**

1. From the OB Flowsheet, click the *Problems* icon in the right navigation pane:



2. In the Problems section, click the second plus (+) icon.
3. In the Problem List window, click *Add ICD* to add a diagnosis code to the patient's Problem List:

The screenshot shows the 'Problem List' window. At the top, there are filters for 'Dx Type' (set to 'All'), 'Clinical Status' (set to 'All'), and a checkbox for 'N.K.P.'. To the right of these filters are buttons: 'Add ICD' (highlighted with a red box), 'Remove', 'Copy to Medical Hx', and 'ICD-10 Migration'. Below the filters is a table with columns: Type, Code, Name, Specify, Notes, Risk, Onset Date, W/U Status, Clinical Status, Added On, Modified On, Modified By, and Resolved On. One row is visible with a green circle icon, code 'I71.4', and name 'Abdominal aortic aneurysm, ...'. At the bottom of the window are buttons for 'Copy', 'View Log', 'OK', and 'Cancel'.

4. Click *OK*.

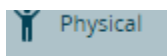
## Enter the Initial Physical Exam

**Path:** *OB Flowsheet > Physical*

Enter the patient's initial physical exam information, including the patient's height, BP, HEENT, *etc.*, in the Physical tab of the OB Flowsheet.

**To add an OB problem to the patient's record:**

1. From the OB Flowsheet, click the *Problems* icon in the right navigation pane:



2. In the Physical section, click the *Edit* icon:

The screenshot shows the 'PHYSICAL' section of the OB Flowsheet. At the top right of the section is an 'Edit' icon (a pencil inside a square, highlighted with a red box). Below the section header is the title 'Initial Physical Examination'. There are two tables side-by-side, each with columns 'Name', 'Value', and 'Remarks'.

Name	Value	Remarks
Date		
BP		
Pre-OB weight		
Psychiatric		
Fundi		
Thyroid		
Respiratory		
Abdomen		
Skin		
External genitalia		
Uterus Size		
Rectum		
Diagonal Conjugate (cm)		
Sacrum		
Gynecoid pelvic type		

Name	Value	Remarks
Height		
Weight		
General		
HEENT		
Teeth		
Breasts		
Cardiovascular		
Extremities		
Lymph Nodes		
Vagina		
Adnexa		
Diagonal Conjugate		
Spines		
Pubic arch		
Trimester of first visit if NOT with grantee		

3. In the Physical window, enter the exam information by selecting options from the drop-down lists and entering notes in the *Remarks* fields:

**Initial Physical Examination**

Name	Value	Remarks
Date	mm/dd/yyyy	
BP		
Pre-OB weight		
Psychiatric		
Fundli		
Thyroid		
Respiratory		
Abdomen		
Skin		
External genitalia		
Uterus Size		
Rectum		
Diagonal Conjugate (cm)		
Sacrum		
Gynecoid pelvic type		

Name	Value	Remarks
Height		
Weight		
General		
HEENT		
Teeth		
Breasts		
Cardiovascular		
Extremities		
Lymph Nodes		
Vagina		
Adnexa		
Diagonal Conjugate		
Spines		
Pubic arch		
Trimester of first visit if NOT with grantee		

Lock Copy Defaults Merge Defaults OK

4. (Optional) Click the *Merge Defaults* button to enter the defaults that have been configured in the OB Flow Admin window.

**Note:** The Initial 'Physical' section is used for documenting certain examination items such as height, BP, HEENT etc.

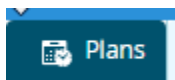
## Entering First, Second, and Third Trimester Plans

**Path:** *OB Flowsheet > Physical*

Enter the plans for the first, second, and third trimester in the Plans tab of the OB Flowsheet.

**To add plans for the patient's first, second, and third trimesters:**

1. From the OB Flowsheet, click the *Plans* icon in the right navigation pane:



2. In the Plans section, click the *Edit* icon.

3. In the Plans window, enter the plans to educate the patient for all three trimesters.

Name	Value	Remarks
HIV and other routine prenatal tests	mm/dd/yyyy	
Risk factors identified by prenatal history	mm/dd/yyyy	
Anticipated course of prenatal care	mm/dd/yyyy	
Nutrition and weight gain counseling	mm/dd/yyyy	
Toxoplasmosis precautions(cats/raw meat)	mm/dd/yyyy	
Sexual activity	mm/dd/yyyy	
Exercise	mm/dd/yyyy	
Environmental/Work hazards	mm/dd/yyyy	
Travel	mm/dd/yyyy	

**Note:** Scroll to display the second and third trimesters.

## OB Visits

Create a new visit, display the care graph, enter the estimated delivery date, order test, and manage medications from the Flowsheet tab.

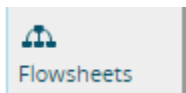
### Creating a New Visit and Entering Notes

**Path:** *OB Flowsheet > Physical*

Create a new OB visit and enter notes in the Flowsheet tab of the OB Flowsheet.

**To create a new visit:**

1. From the OB Flowsheet, click the *Plans* icon in the right navigation pane:



2. In the Plans section, click the plus (+):

Date	Weeks Gest.	Fundal ht. (cm)	Presentation	FHR	Fetal movement	Preterm labor signs	Dilation (cms)	Effacement(%)	Station	Systolic BP	Diastolic BP	Edema	Weight	Total Wt gain	Urine Glucose	Urine Albumin	Next Appt.	Initials
04/12/2016																		

3. In the Flow Sheet window, enter the findings from the visit, or click *Defaults*:

Flow Sheet ( Test, Imm186.22 - 04/12/2016 - NOB )

**Prenatal Visit**

Name	Value	Name	Value
Date	04/12/2016	Weeks Gest.	
Fundal ht.(cm)		Presentation	
FHR		Fetal movement	
Preterm labor signs		Dilation (cms)	
Effacement(%)		Station	
Systolic BP		Diastolic BP	
Edema		Weight	
Total Wt gain		Urine Glucose	
Urine Albumin		Next Appt.	mm/dd/yyyy
Initials			

Lock Defaults OK

**Note:** The *Date* and *Gestational Age* fields automatically populate.

4. Click *OK*.
- The findings display in the Flowsheet.
5. (*Optional*) Check the *Vertical View* box to display the visit findings in a vertical grid:

**FLOW SHEET** [Click to view all visits Vitals](#) ☒ Vertical View +

**Prenatal Visits**

Date	04/12/2016	04/12/2016
Weeks Gest.		
Fundal ht.(cm)		
Presentation		Vertex
FHR		
Fetal movement		
Preterm labor signs		Show
Dilation (cms)		
Effacement(%)		
Station		
Systolic BP		
Diastolic BP		
Edema		
Weight		
Total Wt gain		
Urine Glucose		
Urine Albumin		Trace

6. From the OB Flowsheet, in the *Notes* section, click the plus (+) icon:

**NOTES** +

Date	Notes	Entered By	Updated Date	Initials
04/12/2016	Willis, Sam,Multi : 04/12/2016 10:11:25 EDT - test	Willis, Sam,Multi	04/12/2016	

7. In the Notes window, enter any notes in the *Problem* field, and click *OK*:

## Viewing the Care Graph

**Path:** *OB Flowsheet > Care Graph icon*

**To display the care graph:**

From the OB Flowsheet, click the *Care Graph* icon:

Care Items Due: ()

No Lab/Imaging Items are due.



The patient's gestational age display in red at the top of the graph. Tests identified as requiring immediate attention display in the ASAP column, as well as overdue tests (*Go* orders display in green). Tests for which the patient's gestational age is still below the defined upper gestational age limit display in yellow:

Care Item	ASAP
CBC	

Order labs that are due by selecting the *Order* tab in the *Status* column.



## Entering the EDD

**Path:** *OB Flowsheet > EDD*

Calculate the estimated delivery date (EDD) in the EDD tab of the OB Flowsheet.

**To enter the estimated delivery date:**

1. From the OB Flowsheet, click the *EDD* icon in the right navigation pane.
2. In the EDD window, enter the date next to the LMP, Initial Exam, or Ultrasound that was used to determine the delivery date.
3. Click *Sel* in the row for that method to select the initial EDD.
4. Click *Make Final EDD* to mark this date as the final EDD:

EDD ( Test, Devices - 04/12/2016 - NOB )

Preg Details Physical History Genetics Form A **EDD** Plans Risks Discharge Post Partum

**Initial EDD**

	Date	Weeks	Days	EDD	
LMP	mm/dd/yyyy			mm/dd/yyyy	Sel
Initial Exam	mm/dd/yyyy			mm/dd/yyyy	Sel
Ultrasound	mm/dd/yyyy			mm/dd/yyyy	Sel
Add. Ultrasound	mm/dd/yyyy			mm/dd/yyyy	Sel
<b>Initial EDD:</b>	<b>Make Final EDD</b>				Initials:

**EDD Update**

	Date	Weeks	Days	EDD	
Addl. Ultrasound	mm/dd/yyyy			mm/dd/yyyy	Sel
Addl. Ultrasound	mm/dd/yyyy			mm/dd/yyyy	Sel
Addl. Ultrasound	mm/dd/yyyy			mm/dd/yyyy	Sel
Addl. Ultrasound	mm/dd/yyyy			mm/dd/yyyy	Sel
<b>Final EDD:</b>					Initials:

Lock OK

5. (Optional) Click *Lock* to lock this EDD.

**Note:** The date must be unlocked to be changed after it's been locked. Do not lock the EDD until you are certain it will not be changed.

6. Click *OK*.

## Ordering Lab Tests or Diagnostic Imaging

**Path:** *OB Flowsheet > Labs DI*

Order a lab or diagnostic imaging procedure in the Labs DI tab of the OB Flowsheet.

**To order a lab test:**

1. From the OB Flowsheet, click the *Labs DI* icon in the right navigation pane.

**OR**

If the lab is due based on the *Care Items Due* section, click *Order* next to the lab.

2. In the Labs DI section, click *Order Labs* or *Order Imaging*:

**LABS DI** Classic View Trimester View

Start Date: 04/13/2016

Order Labs Order Imaging e-Cumulative Report

**Labs**

Order Date	Name	Result	Result Date	Reason	Received	Reviewed
------------	------	--------	-------------	--------	----------	----------

**Diagnostic Imaging**

Order Date	Name	Result	Result Date	Reason	Received	Reviewed
------------	------	--------	-------------	--------	----------	----------

3. In the Order Lab window, click *Browse labs*:

**Order Lab**

☒ Automatically add associated CPT codes

Initial Labs due ASAP

**Labs Ordered till now**

Date	Name	Result
------	------	--------

Browse labs Order Selected Labs

4. In the Manage Orders window, enter the name of the order in the search field and click the order.

5. Click *Close*.

The lab is ordered.

## Managing Medications

Continue, refill, or stop current medications, or add new medications from the Treatment window.

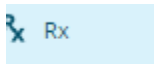
### Continuing, Refilling, or Stopping Current Medications

**Path:** *OB Flowsheet* > *Rx*

Continue, refill, or stop current medications in the Rx tab of the OB Flowsheet.

**To continue, refill, or stop current medications:**

1. From the OB Flowsheet, click the *Rx* icon in the right navigation pane:



2. In the *Rx* section, click the *Edit* icon next to the *Current Medications* section to edit the patient's current medications.
3. Click the *Edit* icon next to the *Allergies* section to add allergies to the patient's record.

4. In the Treatment section, click the *Edit* icon to prescribe a new medication or enter instructions for a current medication:
  - a. In the Treatment window, click *Cur Rx*:

- b. In the Manage Orders window, select the appropriate instruction for the patient's current medications:

- C: Continue taking the medication
  - R: Refill
  - 30: 30-day Refill
  - 90: 90-day Refill
  - S: Stop taking the medication
- c. Click *OK*.

## Adding New Medications

**Path:** *OB Flowsheet > Rx*

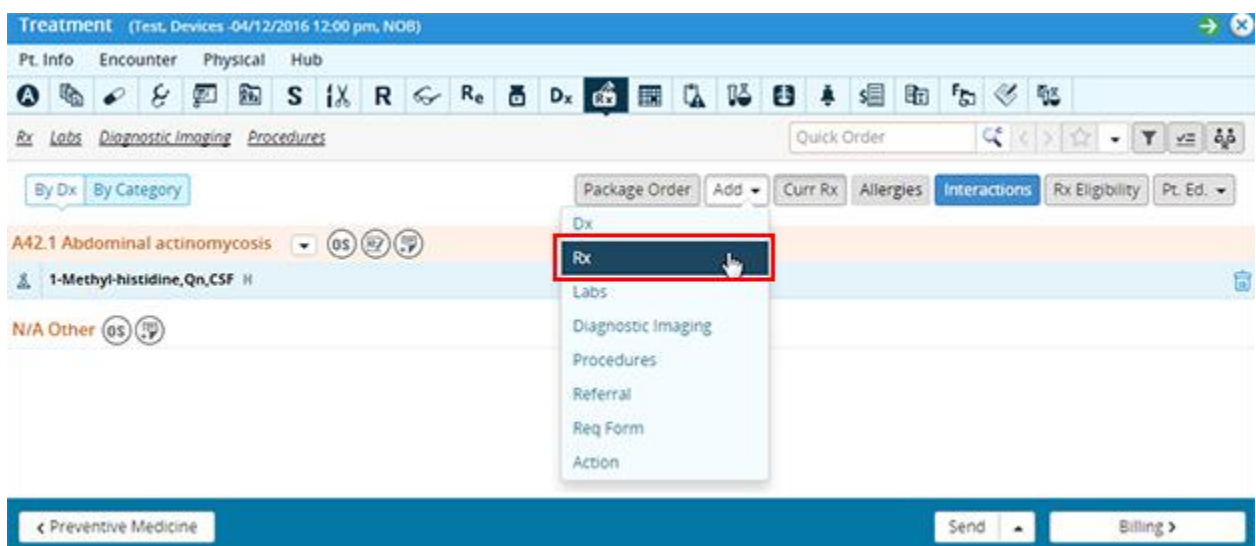
Continue, refill, or stop current medications in the Rx tab of the OB Flowsheet.

**To add a new medication:**

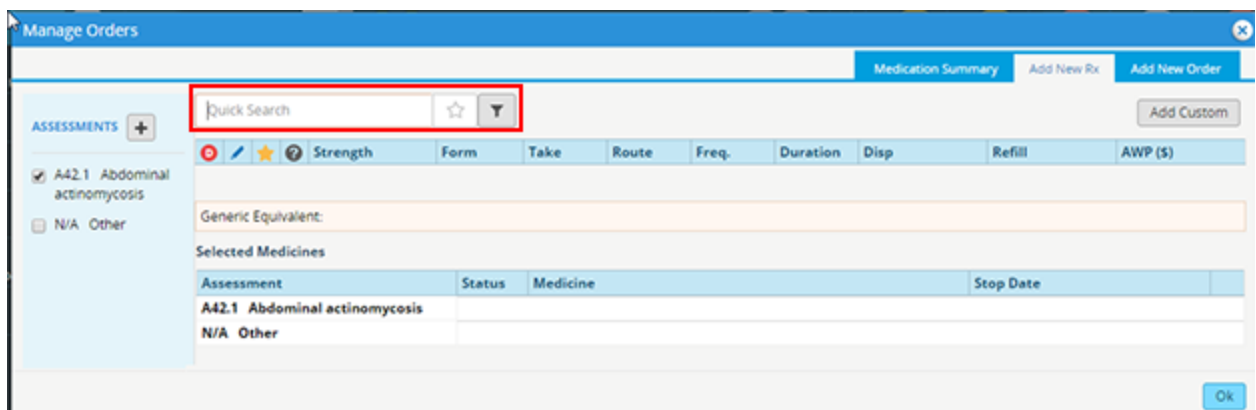
1. From the OB Flowsheet, click the *Rx* icon in the right navigation pane:



2. In the Treatment section, click the *Edit* icon to prescribe a new medication or enter instructions for a current medication.
3. In the Treatment window, click *Add*, and select *Rx* from the drop-down list:



4. In the Manage Orders window, search for the medication in the *Quick Search* field:



5. Select the correct dosage.

The medication is added to the *Selected Rx* section of the window.

## Post-Partum

Enter discharge information, post-partum findings, and close the pregnancy.

### Entering Discharge Information

**Path:** *OB Flowsheet > Discharge*

Document the discharge information in the Discharge tab of the OB Flowsheet.

**To enter discharge information:**

1. From the OB Flowsheet, click the *Discharge* icon in the right navigation pane:



2. In the Discharge window, enter the discharge information:

Discharge ( Test, Devices - 04/12/2016 - NOB )

Preg Details Physical History Genetics Form A EDD Plans Risks **Discharge** Post Partum

**Delivery Dates**

Name	Value
Delivery Date	mm/dd/yyyy
Discharge Date	mm/dd/yyyy
Delivery at(weeks)	

**Intrapartum Complications**

Name	Value
None	
Hemorrhage	
Infection	
Hypertension	
Other	

**Delivery Info**

Name	Value
Labor	
Anesthesia	
Vaginal	
Cesarean	
Tubal Sterilization	
Note	

Lock Copy Defaults Merge Defaults OK

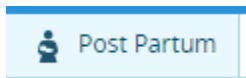
## Entering Post-Partum Information

**Path:** *OB Flowsheet > Post Partum*

Document the post-partum information in the Post Partum tab of the OB Flowsheet.

**To enter post-partum information:**

1. From the OB Flowsheet, click the *Post Partum* icon in the right navigation pane:



2. In the Post Partum window, enter the post-partum information by selecting options from the drop-down lists, and entering notes in the *Remarks* fields:

A screenshot of the 'Post Partum' window. The title bar says 'Post Partum ( Test, Devices - 04/12/2016 - NOB )'. Below the title bar is a navigation bar with tabs: Preg Details, Physical, History, Genetics, Form A, EDD, Plans, Risks, Discharge, and Post Partum. The main area has a table with columns: Name, Value, and Remarks. The 'Name' column has two rows: 'Surgical Sterilization' and 'Contraception'. The 'Value' column has two empty drop-down menus. The 'Remarks' column has two empty text areas. At the bottom of the window are four buttons: Lock, Copy Defaults, Merge Defaults, and OK.

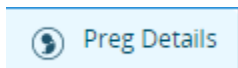
## Closing the Pregnancy

**Path:** *OB Flowsheet > Preg Details*

Close the pregnancy in the Preg List tab of the OB Flowsheet.

**To close the pregnancy:**

1. From the OB Flowsheet, click the *Preg Details* icon in the right navigation pane:



2. In the Preg List section, enter the discharge date for the pregnancy and click *Close Pregnancy*:

A screenshot of the 'PREG LIST' section. It shows a table with columns: Sr. No, Status, Father First Name, M. Initial, Father Last Name, Discharge Date, OB Provider, No. of Expected Children, and Notes. The first row has '1' in 'Sr. No', 'Open' in 'Status', and 'Dwyne, Jhonson' in 'OB Provider'. To the right of the table is a 'Close Pregnancy' button, which is highlighted with a red box.

## Printing or Faxing an OB Flowsheet

**Path:** *OB Flowsheet > Print icon*

Print or fax the OB Flowsheet.

**To print or fax the OB Flowsheet:**

1. From the OB Flowsheet, click the *Print* icon:

**OB Chart** [Print icon] [SB icon] [Share icon]

PN CP [SB icon] [Share icon] [V] 04

**Devices Test (51 Y)** 01/01/1965

G: - P: -, -, -, - EDD: 01/18/2017 GA: 0 (Wks) 0 (Days)

Translator: **NO** EMERGENCY CONTACT NO. FATHER INFORMATION

Ethnicity: Race: **Asian**

Language: Interpretation Service Requested: **No**

Req No: **9130.25158**

Primary Insurance: **BCBS MA**

Provider: **Sam Willis, MD**

Referring Provider:

**Risk Assessment:**

**High Risk**

At Risk

Genetics

Infection

Problem

STICKY NOTES

2. In the Pregnancy Summary Report window, select the report format and the sections to print:

**Pregnancy Summary Report**

Preg: 04/12/2016 Test Facility

Select Template

- ☒ All
- ☒ Preg List
- ☒ Physical
- ☒ History
- ☒ Genetics
- ☒ Form A
- ☒ Flow Sheet
- ☒ Notes
- ☒ EDD
- ☒ Plans
- ☒ Rx
- ☒ Labs DI
- ☒ Graphs
- ☒ Risks
- ☒ Problems
- ☒ Discharge
- ☒ Post Partum

**Devices Test (51 Y)** 01/01/1965

Translator: **NO**

Ethnicity: Race: **Asian**

Language: Interpretation Service Requested: **No**

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Primary Insurance: **BCBS MA**

Provider: **Sam Willis, MD**

Referring Provider:

EMERGENCY CONTACT NO. FATHER INFORMATION

G: - P: -, -, -, - EDD: 01/18/2017 GA: 0 (Wks) 0 (Days)

Risk Assessment: **High Risk**

At Risk

Problem

Genetics

Infection

**Preg List**

Sr. No	Status	Father First Name	M. Initial	Father Last Name	Discharge Date	OB Provider	No. of Expected Children	Notes
1	Open					Dwyne, Jhonson		

**Initial Physical Examination**

Name	Value	Remarks
Date		
Height		

Send

3. From the *Send* drop-down list, click *Print* or *Fax*.



# OBGYN Billing

## Global Billing

The global prenatal/delivery/postpartum fee is reimbursable when one physician or physician group practice provides the entire patient's obstetric care. Global prenatal care includes all prenatal visits performed at medically appropriate intervals up to:

- The date of delivery.
- Routine urinalysis testing during the prenatal period.
- Care for pregnancy related conditions (e.g. nausea, vomiting, cystitis, and vaginitis).
- The completion of the *Risk Appraisal for Pregnant Women* form.

Only one prenatal care code, 59425 (4-6 visits) or 59426 (7 or more visits), may be billed per pregnancy. The date of the delivery is the date of service to be used when billing the global prenatal codes. If a provider does more than three visits but the participant goes to another provider for the rest of her pregnancy, all visits must be billed using the appropriate office visit procedure codes.

**Billing** Jones, Mary -03/02/2017 10:00 am, OBGYN

Pt. Info Encounter Physical Hub

ICD Description Add ICD Auto Map to ICD10

P	Code	Diagnosis	Specify	Notes
1	Z34.80	Encounter for supervision of normal pregnancy in...		

CPT Description Add E&M Add CPT EM Codes Medicare Edits Pop Up

CPT	Name	Units	M1	M2	M3	M4	ICD1	ICD2	ICD3	ICD4	Notes
99499	UNLISTED E&M SERVICE	1.00					1 Z34.80				

Billing Notes

Follow Up S Reason Prenatal Visit

2-3 Ds 1 W 2 W 3 W 4 W 6 W 2 M 3 M 4 M 6 M 1 Y pm

Follow up N/A

Treatment Addl. Billing Date Close Done

**Billing** (Jones, Mary -03/02/2017 10:00 am, OBV)

Pt. Info Encounter Physical Hub

Q ICD Q Description < > Add ICD Auto Map to ICD10

	P	Code	Diagnosis	Specify	Notes
1		N91.2	Absence of menstruation		
2		Z32.01	Pregnancy examination or test, positive result		
3		Z36	1st trimester screening		

Q CPT x Q Description < > Add E&M Add CPT EM Coder Medicare Edits Pop Up

CPT	Name	Units	M1	M2	M3	M4	ICD1	ICD2	ICD3	ICD4	Notes
81025	URINE PREGNANCY TEST	1.00					1 N91.2				
81002	URINE-NO MICRO	6.00					2 Z32.01				
99205	Office Visit, New Pt., Level 5	1.00					1 N91.2	2 Z32.01	3 Z36		
76817	TRANSVAGINAL US, OBSTETR...	1.00					3 Z36				

**Billing Notes** ... Clr Follow Up S ... Clr Reason ... Clr

2-3 Ds 1 W 2 W 3 W 4 W 6 W  
2 M 3 M 4 M 6 M 1 Y prn

Follow up N/A

← Treatment Addl. Billing Data Close Done

**Billing** (Jones, Mary -03/02/2017 10:00 am, OBV)

Pt. Info Encounter Physical Hub

Q ICD Q Description < > Add ICD Auto Map to ICD10

	P	Code	Diagnosis	Specify	Notes
1		Z34.80	Encounter for supervision of normal pregnancy in...		

Q CPT Q Description < > Add E&M Add CPT EM Coder Medicare Edits Pop Up

CPT	Name	Units	M1	M2	M3	M4	ICD1	ICD2	ICD3	ICD4	Notes
59426	ANTEPARTUM CARE ONLY	1.00					1 Z34.80				

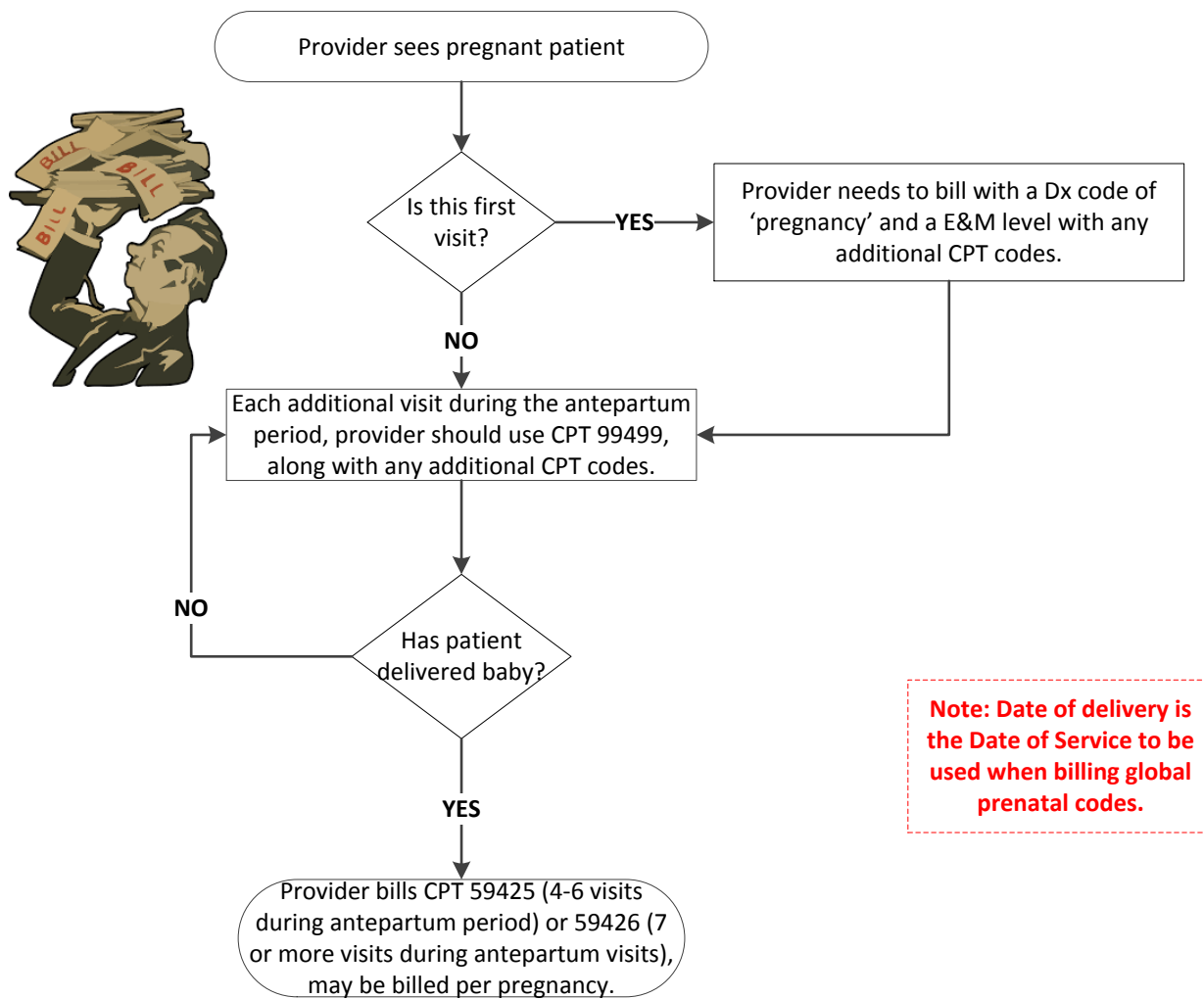
**Billing Notes** ... Clr Follow Up S ... Clr Reason ... Clr

2-3 Ds 1 W 2 W 3 W 4 W 6 W  
2 M 3 M 4 M 6 M 1 Y prn

Follow up N/A

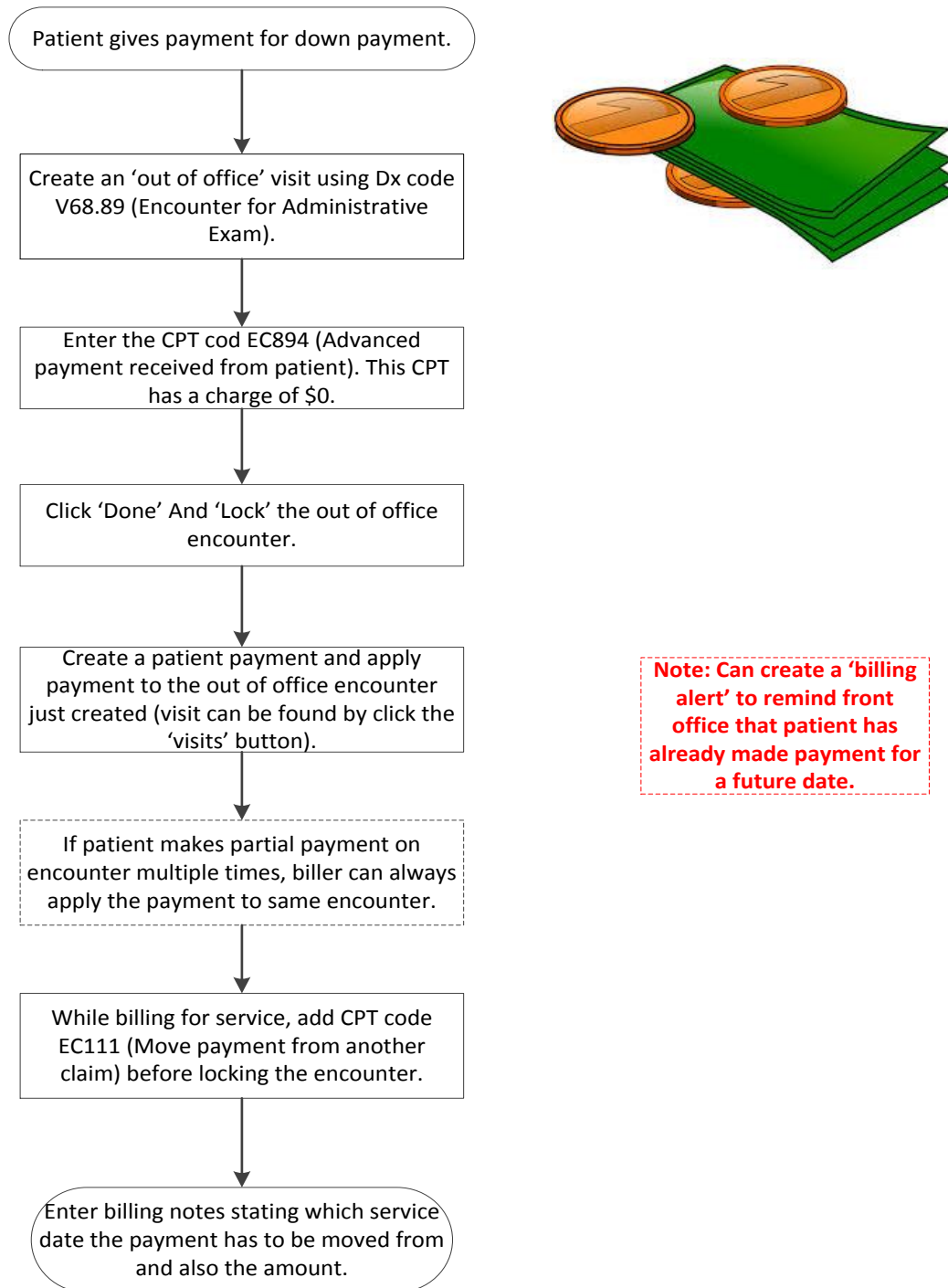
← Treatment Addl. Billing Data Close Done

## OBGYN Billing Workflow



## OB Down Payment Workflow

The workflow below represents how to apply payments for patients who are on a payment plan (optional).



# APPENDIX A: NOTICES

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